Minutes

Date: 02nd of May 2016
Time: 12 pm
Venue: Teleconferencing

Present: Greg Anderson, Joe Yip, Mike Pankhurst, Kathy Mountjoy,

Apologies: Richard Carroll, Stella Milsom, Stephen Bunn, Chris Charles, Chris McMahon, Ryan Paul, Susannah O'Sullivan

Approve Minutes of previous meeting:

Matters arising from Minutes dated 14th March 2016:

Incoming Correspondence:

1. **15 March 2016** Dr Elizabeth McKenzie, Research Fellow (Metabolomics), Liggins Institute, University of Auckland asking for interest in having Dr Matthias Auer to give seminar. He is specialist-in-training from the Max Planck Institute of Psychiatry, Department of Internal Medicine, Endocrinology and Clinical Chemistry, Germany. He has been carrying out some interesting metabolomics analyses of the health effects of cross-hormone therapy in transgender patients.
2. **17 March 2016** Dr Andrew Cleland, Chief Executive of RSNZ – Reminder of the next RSNZ Constituent Organization Forum Day on the 11 May 2016. Proposed program/ format is included. Refer Appendix.
3. **02 April 2016** Paul Mitchell, Chair of the Board of Trustees Osteoporosis New Zealand – welcoming feedback on the "Clinical Standards for Fracture Liaison Services in NZ" draft . Deadline 06 May 2016. Refer Appendix.
4. **22 April 2016** Deidre Carwell Personal Assistant of Dr Carl Eagleton (Clinical Director) of Medicine, Middlemore Hospital confirmed that Dr Bryan Mclvor no longer require sponsor from NZSE to ANZHNCS and IFHNOS meeting 2016 in Auckland, 27-30 October 2016. It will now be sponsored by Novartis.
5. **22 April 2016** Emily Lloyd, Funding and Award administrator at Royal College of Physicians of London – requesting to advertise a fellowship open to suitably qualified endocrinologist wishing to visit UK. Info of the fellowship is available at this website (https://www.rcplondon.ac.uk/samuel-leonard-simpson-fellowships-endocrinology). Applications are open until 01 August 2016.
6. **29 April 2016** Yolandi Nortier, Marketing Associate (NZ), Eli Lilly Company – sent a sponsorship agreement to be completed, signed and returned. She has also requested an

invoice from NZSE to arrange a purchase order. The company will have 2 representatives to attend the conference.

Outgoing Correspondence:

1. **15 Feb 2016** Requested Andrea Van Rinsvelt from Sizzle sites to prompt a message "reviewed at the next committee meeting (held every 6 weeks)" once an application for membership has been submitted online to to give general idea for applicants as to when their application will be reviewed.
2. **29 April 2016** Returned a completed and signed sponsorship agreement and an invoice (NZ$5000) to Yolandi Nortier from Eli Lilly Company.

Items:

1. Due to the low number of NZSE exec attendance to this teleconference, the discussion items below have been deferred to next meeting on the 13th of June 2016.
   - Discussions with other scientific societies regarding formation of a Federation of Experimental Biologists to advocate on issues such as QRW structure
   - 2016 NZSE budget.
   - MedSci and Clinical Meeting update. Nancy Sirett lecture to be held this year?

2. We have agreed to advertise a fellowship open to suitably qualified endocrinologist wishing to visit UK on behalf of Royal College of Physicians of London as stated in Incoming Correspondence, Point 5.

Treasurer's Report:

Account balances:
Current account: $19, 035.48
Term deposit 1: $40, 000.00
Term deposit 2: $11, 932.06
Term deposit 3: $20, 860.44

Transactions since last meeting:

1) Greg Anderson: Reimbursement for Payment to Greymouse telecomm. $103.00
2) Sizzle Sites: Biannual security/software/site updates $180.00

New Member applications: 4

All four new membership applicants below were reviewed and accepted.

16 March 2016: Miss Alana Gould, Part-timed salaried clinical practice, Wellington Regional Hospital. Clinical interest: Brain/ Pituitary and General endocrinology.

05 April 2016: Dr Belinda Schouten, Part-timed salaried clinical practice, Christchurch Hospital. Member of FRACP. Clinical interest: General endocrinology

06 April 2016: Miss Amber Tait, Clinical Practice, Christchurch Hospital. Clinical interest: Brain/ Pituitary, Growth and General endocrinology

08 April 2016: Miss Jade York, Research student (nominated by Dr Joe Yip), University of Otago. Research interest: Brain/ Pituitary and reproductive endocrinology.

Full members: 41 paid, 42 “expired”
Student members: 7 paid, 28 “expired”
Life Members: 5

Other Business:

Meeting closed: 12.25pm

Next Meeting: 13 June 2016

Appendix

Instructions for joining the meeting by teleconference:

Dial one of the numbers below and type the conference number: **75569** followed by # at the prompt.

Toll Free (free for you…costs NZSE 18c/min)	0800 896 206
Auckland (costs NZSE 9.5c/min)	09-951 8378
Christchurch (costs NZSE 9.5c/min)	03-288 0084
Wellington (costs NZSE 9.5c/min)	04-831 9424

RSNZ Constituent Organisations' Forum Day

Dear Constituent Organisation officer

At the last RSNZ Constituent Organisations' Forum Day in November 2015 there was a consensus reached the next one be held in six months. Accordingly, we have set **Wednesday 11 May** as the date of the next Constituents' Forum. The proposed format will be similar to last year. This involved a start at 10am with the goal of wrapping up by 4.00 pm. The session programme is proposed to be:

10 am	Introductions
10.15 am	Plenary session (Constituents' Forum)
12.15 pm	Lunch
12.45 pm	Parallel sessions (Discipline-based Forums)
3.00 pm	Report back and summation

Draft Plenary Session Agenda

1. Presidential or Chief Executive briefing (10-15mins)
   a. What does new RSNZ strategic plan mean for COs?
   b. What did the RSNZ learn in its survey of the research community?
   c. RSNZ's international strategy
2. Diversity – what are good practices we can share, how do we learn from each other?
3. Good practice guidance – what has or is been done and how can it help COs?
   a. Externally focussed e.g. researcher guidelines for public engagement
   b. Internally focussed e.g. changes to incorporated society legislation, expertise listings
4. The CO membership proposition
   a. What do (and what should) COs expect from their membership (given the user pays principle should apply)?
   b. How can the CO membership be further diversified ?
5. Other items pre-notified by COs

Draft Agenda for the three parallel Discipline-based Forums (Humanities and social sciences; biological and life sciences, physical, mathematical and technological sciences and engineering)

1. Overview of expert or practice advice in progress
2. Identification of issues within a discipline or across a number of disciplines

a. Is it an expert or practice advice issue or an issue related to good practice in running a membership society?
b. Who is the audience?
c. What makes the issue significant enough to commit resources to addressing it?
d. What approach is suited to resolving the issue?

Draft Agenda for the Closing Plenary session

1. Report-backs from three parallel sessions
2. Identification of common issues across COs
3. Next Forum – six or 12 months?

Briefing papers will be distributed one month in advance and will comprise:

· Agenda
· Notes of last Forum
· Overview of key things that the RSNZ has done since that forum to address issues raised
· RSNZ strategic plan

Please notify me as soon as possible with any suggestions for the agenda.

Each CO is entitled to select its own representative, but the norm is for the representative to be a member of the governing body of the CO, and often the chair or president. The Society may also choose to allow other groups which are not COs, but which could contribute positively to send a representative. Given the numbers involved, we do need to restrict attendance to a single representative per organisation.

Each CO is responsible for meeting the travel costs of its representative, but you may apply for a grant in aid of $100.00 from the Society. We would be grateful if you could confirm your organisation's attendance and the name of your representative to Nanette Lowe (membership@royalsociety.org.nz) as soon as possible.

The President (Richard Bedford), Vice Presidents (Gaven Martin and Richard Le Heron), the Councillor representing COs (Liz Gordon), Society staff and I look forward to talking to you all. Unfortunately our third Vice President, Barry Scott will be overseas on an international fellowship programme.

Andrew

Consultation on New Zealand Clinical Standards for Fracture Liaison Services

Osteoporosis New Zealand has been collaborating with the Ministry of Health and the Accident Compensation Corporation, in addition to many clinical stakeholders in New Zealand, to support implementation of Fracture Liaison Services (aka Secondary Fracture Prevention Programs). Since 2013, very encouraging progress has been made with FLS implementation in NZ.

Accordingly, as many services are now in place, Osteoporosis NZ has drafted the attached Clinical Standards for FLS in New Zealand. The contents of these standards have been informed by similar documents/initiatives developed inCanada and the UK, which have been endorsed by learned societies in both countries. Further, the International Osteoporosis Foundation (IOF) has developed internationally endorsed standards through their Capture the Fracture® Program. The purpose of these Clinical/Quality Standards is to clearly articulate the key functions of an effective FLS, and how those key functions can be readily measured by the FLS team to inform ongoing internal review of performance.

We are conducting a consultation with learned societies on the content of the draft NZ Clinical Standards and would welcome feedback from NZSE. If NZSE would like to comment upon the draft, I would be grateful if any suggested amendments could be made via Tracked Changes to the attached MS Word document, and be provided to myself by email by end of business on Friday 6 May 2016.

A final draft will be produced to reflect suggestions made in the consultation exercise. The final draft will be circulated to learned societies to seek their endorsement of the Clinical Standards. The final step in the process will be to disseminate the Clinical Standards to all relevant organisations in NZ, including the District Health Boards (DHBs), Primary Health Organisations (PHOs) and all relevant professional organisations and learned societies.

OSTEOPOROSIS NEW ZEALAND
Better bones, fewer fractures

Clinical Standards for Fracture Liaison Services in New Zealand

Draft for consultation – Deadline for comments Friday 6 May 2016
Version 1.0 - 1 April 2016
Author: Paul Mitchell, Chair, Osteoporosis New Zealand

Fracture Liaison Services

A Fracture Liaison Service (FLS) systematically identifies individuals within a local population aged 50 years and over who have suffered a fragility fracture, with the intention of preventing subsequent fractures. A fragility fracture is defined as a fracture resulting from low trauma, such as a fall from standing height[1]. The most common skeletal sites of fragility fractures are the hip, wrist, humerus, pelvis or spine. It should be noted that a significant proportion of spine fractures are undiagnosed or do not come to clinical attention[2].

FLS have been demonstrated in many countries to significantly improve the process of secondary preventive care, which comprises both osteoporosis assessment and management, and interventions to prevent future falls[3]. FLS reduce re-fracture rates[4-7] and are cost-effective[8-11]. A study from the Netherlands suggests that FLS may also reduce post-fracture mortality[7].

The Minister of Health expected that all District Health Boards (DHBs) have established a fully operating FLS by June 2015 in order to reduce the number of future fractures suffered by older New Zealanders[12].

Clinical Standards for Fracture Liaison Services

Clinical or Quality Standards for FLS have been developed in Canada[13] and the UK[14, 15]. The International Osteoporosis Foundation (IOF) has also developed internationally endorsed standards for FLS in the form of the Capture the Fracture® Best Practice Framework[16-18]. The purpose of these documents is to set evidence-based standards of post-fracture care that health professionals and patients should expect. In 2015, the National Osteoporosis Society (NOS) in the UK published standards drafted by a multidisciplinary group which were endorsed by all relevant national professional organisations and IOF[15]. The NOS standards were based on a so-called '5IQ' approach, relating to the key functions of an FLS:

- Identification
- Investigation
- Information
- Intervention
- Integration
- Quality

This is the approach which underpins the New Zealand Clinical Standards for FLS. Further, as these standards are adherent to the principles of the IOF Capture the Fracture® standards, FLS in New Zealand should consider submitting their service for IOF Best Practice Recognition, as six FLS in New Zealand had done by April 2016[19].

Endorsing organisations

The following organisations endorse the New Zealand Clinical Standards for FLS:
Insert logos of organisations which decide to endorse the final Clinical Standard document

Clinical Standards for Fracture Liaison Services in New Zealand

Standard 1: Identification

All men and women aged 50 years and over who suffer a fragility fracture will be systematically and proactively identified by the FLS.

Measurement: The proportion of all fragility fracture patients aged 50 years and over presenting to urgent care services in the local population that are identified by the FLS. This includes patients presenting with fractures to hospital Emergency Departments (EDs), community-based Accident and Emergency Medical Clinics or General Practitioners (GPs). In the event that the total number of fractures in a local population is unknown, it can be estimated by multiplication of the total number of hip fractures occurring in men and women aged 50 years and over by a factor of 5.

Standard 2: Investigation

Fragility fracture sufferers will undergo an assessment for future fracture risk including bone health (i.e. osteoporosis) and falls risk.

Measurement: The proportion of fragility fracture sufferers identified who undergo:

i. Bone health assessment within 8 (? or 12) weeks of the fracture presentation. It should be noted that physicians may determine that an individual's clinical history may be sufficient to warrant initiation of osteoporosis treatment without undertaking bone mineral density (BMD) testing to confirm a diagnosis of osteoporosis. Individuals in whom progression to immediate osteoporosis treatment is deemed clinically appropriate can be considered to have undergone a bone health assessment.
ii. Falls risk assessment within 8 (? or 12) weeks of the fracture presentation.

Standard 3: Information

Fragility fracture sufferers will be provided with written information on bone health, lifestyle measures, nutrition and osteoporosis treatments.

Measurement: The proportion of fragility fracture sufferers identified who receive a package of written information.

Standard 4: Intervention

Fragility fracture sufferers determined to be at high risk of suffering future falls and fractures will be offered appropriate osteoporosis treatment with PHARMAC subsidised treatments and be referred for interventions to reduce falls risk.

Measurement: The proportion of fragility fracture sufferers investigated who:

i. Are offered PHARMAC subsidised osteoporosis treatment within 8 (? or 12) weeks of the fracture presentation.
ii. Are referred for evidence-based interventions to reduce falls risk within 8 (? or 12) weeks of the fracture presentation.

Note to consulting organisations. A New Zealand Osteoporosis Clinical Guideline is currently in development. This guideline will be published in Q1-2017. In the absence of a current clinical guideline, the above wording is suggested as a 'stop-gap' during 2016. When the NZ Osteoporosis Clinical Guideline is published in early 2017, we suggest that this Standard is re-

worded to state that intervention of osteoporosis treatments should be in accordance with the new guidelines.

Standard 5: Integration

The FLS provides the fragility fracture sufferer's GP with a patient-centred long-term care plan to reduce falls and fracture risk, and promote long-term management.

Measurement: To include:

i. Proportion of fragility fracture sufferers who receive a copy of the long-term care plan sent to their GP.
ii. Proportion of fragility fracture sufferers who were initiated on osteoporosis treatment within 8 (? or 12) weeks of the fracture presentation. This includes both individuals who received treatment initiated directly by the FLS and individuals who were initiated on treatment as a result of the long-term care plan being sent to the individual's GP.
iii. Proportion of all fragility fracture sufferers who were initiated on treatment who continued to take that treatment at 6 (? or 12) months.

Standard 6: Quality

The FLS will undertake an annual performance review which will include analysis of the quality of FLS process implementation according to adherence with Standards 1 – 5 and levels of Continuing Professional Development (CPD) by FLS staff.

Measurement: To include:

i. The first year of FLS operations will provide a baseline for future evaluation of performance against Standards 1 – 5.
ii. Review of relevant CPD undertaken by FLS staff and identification of training needs.

Acknowledgements

Osteoporosis New Zealand would like to thank the National Osteoporosis Society in the UK for the opportunity to base these standards on the approach taken in their document *Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services*. We also appreciate the work of Osteoporosis Canada, the British Orthopaedic Association and the International Osteoporosis Foundation which has informed development of these standards.

References

1. Eisman JA, Bogoch ER, Dell R, et al. Making the first fracture the last fracture: ASBMR task force report on secondary fracture prevention. *J Bone Miner Res.* Oct 2012;27(10):2039-2046.
2. Delmas PD, van de Langerijt L, Watts NB, et al. Underdiagnosis of vertebral fractures is a worldwide problem: the IMPACT study. *J Bone Miner Res.* Apr 2005;20(4):557-563.
3. Akesson K, Mitchell PJ. *Capture the Fracture: A global campaign to break the fragility fracture cycle.* Nyon,: International Osteoporosis Foundation; 2012.
4. Dell R, Greene D, Schelkun SR, Williams K. Osteoporosis disease management: the role of the orthopaedic surgeon. *J Bone Joint Surg Am.* Nov 2008;90 Suppl 4:188-194.
5. Lih A, Nandapalan H, Kim M, et al. Targeted intervention reduces refracture rates in patients with incident non-vertebral osteoporotic fractures: a 4-year prospective controlled study. *Osteoporos Int.* Mar 2011;22(3):849-858.
6. Van der Kallen J, Giles M, Cooper K, et al. A fracture prevention service reduces further fractures two years after incident minimal trauma fracture. *Int J Rheum Dis.* Feb 2014;17(2):195-203.
7. Huntjens KM, van Geel TA, van den Bergh JP, et al. Fracture liaison service: impact on subsequent nonvertebral fracture incidence and mortality. *J Bone Joint Surg Am.* Feb 19 2014;96(4):e29.
8. Sander B, Elliot-Gibson V, Beaton DE, Bogoch ER, Maetzel A. A coordinator program in post-fracture osteoporosis management improves outcomes and saves costs. *J Bone Joint Surg Am.* Jun 2008;90(6):1197-1205.
9. Department of Health. Fracture prevention services: an economic evaluation.; 2009.
10. McLellan AR, Wolowacz SE, Zimovetz EA, et al. Fracture liaison services for the evaluation and management of patients with osteoporotic fracture: a cost-effectiveness evaluation based on data collected over 8 years of service provision. *Osteoporos Int.* Jul 2011;22(7):2083-2098.
11. Cooper MS, Palmer AJ, Seibel MJ. Cost-effectiveness of the Concord Minimal Trauma Fracture Liaison service, a prospective, controlled fracture prevention study. *Osteoporos Int.* Jan 2012;23(1):97-107.
12. Ministry of Health. Annual Plan Guidance: Working draft 2014/15 Toolkit Annual Plan with statement of intent. Wellington.; 2013.
13. Osteoporosis Canada. *Quality Standards for Fracture Liaison Services in Canada.* Toronto: Osteoporosis Canada; 2014.
14. British Orthopaedic Association, National Osteoporosis Society. *BOAST 9: Fracture Liaison Services.* London 2014.
15. Gittoes N, McLellan AR, Cooper A, et al. *Effective Secondary Prevention of Fragility Fractures: Clinical Standards for Fracture Liaison Services.* Camerton: National Osteoporosis Society; 2015.
16. Akesson K, Marsh D, Mitchell PJ, et al. Capture the Fracture: a Best Practice Framework and global campaign to break the fragility fracture cycle. *Osteoporos Int.* Aug 2013;24(8):2135-2152.
17. Javaid MK, Kyer C, Mitchell PJ, et al. Effective secondary fracture prevention: implementation of a global benchmarking of clinical quality using the IOF Capture the Fracture(R) Best Practice Framework tool. *Osteoporos Int.* Nov 2015;26(11):2573-2578.
18. International Osteoporosis Foundation. Capture the Fracture® Programme website. http://www.capture-the-fracture.org/. Accessed 1 April 2016.
19. International Osteoporosis Foundation. Map of best practice. http://www.capture-the-fracture.org/map-of-best-practice. Accessed 1 April 2016.